Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALEX MOMPOINT MD
3100 TIMMONS LANE SUITE 250
HOUSTON TX 77027

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-1702-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not include a position summary with their response to the dispute.

Response Submitted by: Gallagher Bassett, 16414 San Pedro #950, San Antonio, TX 78232

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 27, 2011	CPT Code 99456-W5-WP	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 27, 2011
   - No denial reason codes were listed on explanation of benefits.

Explanation of benefits dated October 26, 2011

- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL, ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.

Issues

1. Were the services in dispute appropriately billed?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $650.00 for CPT code 99456-W5-WP with 1 (one) unit in Box 24G of the CMS-1500 for a Division ordered Designated Doctor examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). The Division order on the EES14 and DWC032 was to determine Maximum Medical Improvement/Impairment Rating (MMI/IR).
2. Review of the submitted documentation supports that Maximum Medical Improvement (MMI) was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Review of the narrative documentation submitted supports the rating of the right wrist (upper extremity) with the Range of Motion (ROM) Impairment Rating method per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). The Impairment Rating per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the right wrist is per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) and the Maximum Allowable Reimbursement (MAR) for the Impairment Rating is $300.00. The combined Maximum Allowable Reimbursement (MAR) for the disputed CPT code 99456-W5-WP is $650.00.
3. The respondent has previously reimbursed the amount of $500.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is entitled to additional reimbursement of $150.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 27, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.